Commonwealth of Kentucky
Cabinet for Health and Family Services
Office of Health Policy (OHP)

State Innovation Model (SIM) Model Design

May Stakeholder Meeting

May 6, 2015

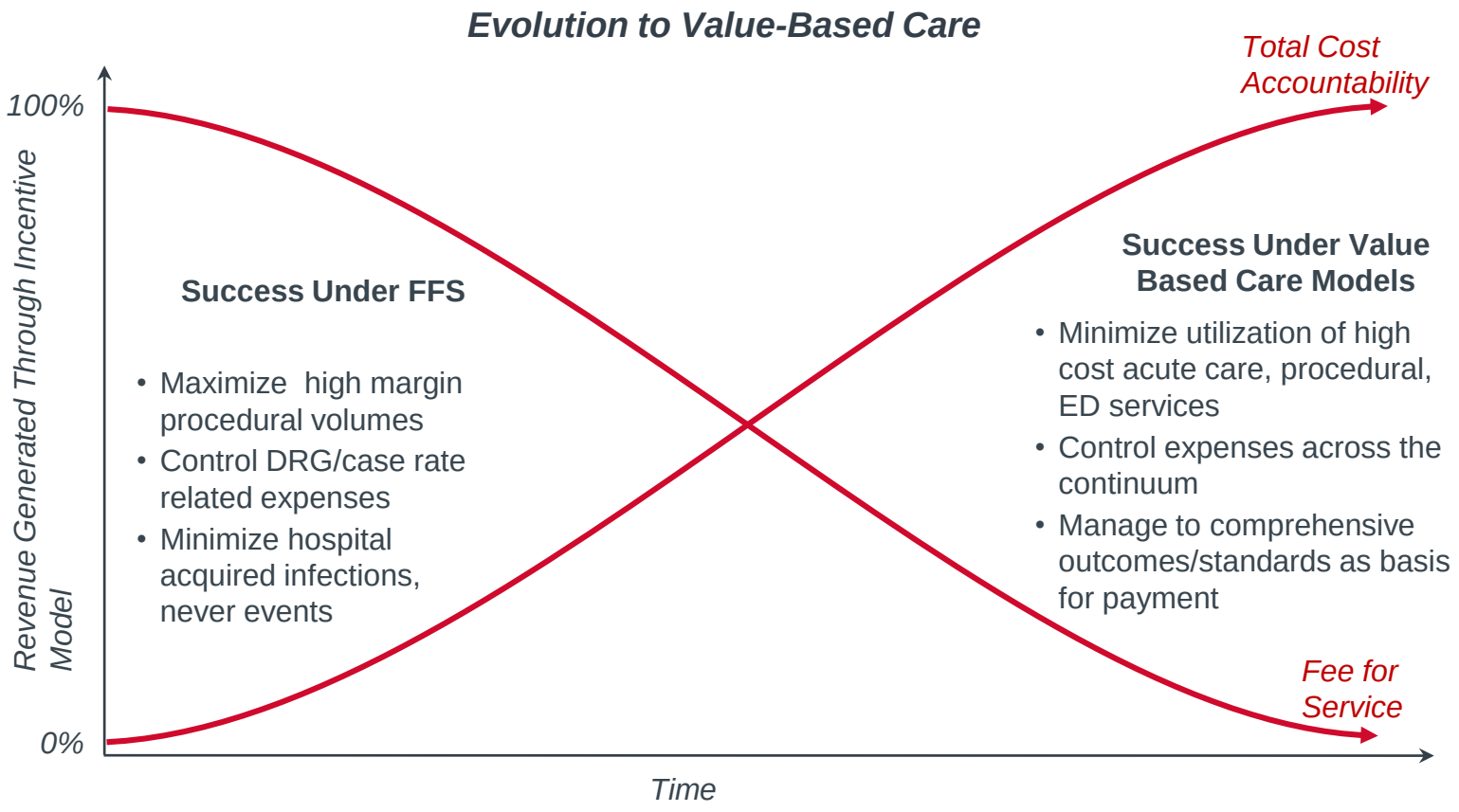
Meeting Agenda

▪ **Welcome and Introductions** (Eric Friedlander, Deputy Secretary, Kentucky Cabinet for Health and Family Services)	1:00 – 1:15 PM
▪ **Driving from Volume to Value: An Overview of Select Payment Innovation Models** (Dr. Dennis Weaver, Executive Vice President and Chief Medical Officer, The Advisory Board Company, Inc.)	1:15 – 2:30 PM
▪ *Break*	2:30 – 2:45 PM
▪ **April Workgroup Meetings: Recap and Report Out** (Jim Hardy, Specialist Leader, Deloitte Consulting LLP)	2:45 – 3:15 PM
▪ **Population Health Improvement Plan (PHIP) Draft Overview** (Dr. Stephanie Mayfield Gibson, Commissioner, Department for Public Health and Dr. John Langefeld, Chief Medical Officer, Department for Medicaid Services)	3:15 – 3:40 PM
▪ **Q&A** (Emily Parento, Executive Director, Office of Health Policy, CHFS)	3:40 – 3:55 PM
▪ **Next Steps** (Jim Hardy, Specialist Leader, Deloitte Consulting LLP)	3:55 – 4:00 PM

Driving from Volume to Value: An Overview of Select Payment Innovation Models

The Central Challenge Still Confronting Providers

Shifting Paradigm Requires Navigating Two Disparate Payment Models



Center for Medicare Services (CMS) Drives Payment Reform

It accelerated with passage of the Affordable Care Act (ACA)

Key Elements impacting Health Care Providers spurred by the ACA:

- Medicaid Coverage Expansion
- Launch of Health Insurance Exchanges
- Implementation of Value Based Purchasing Program, Hospital Readmission Reduction Program and Hospital Acquired Condition Penalty Program
- All Initiatives include multiyear payment reform models

- Promotion of Alternate/Accountable Payment Models
  - Bundled Payment for Care Improvement Initiative
  - Pioneer Accountable Care Organizations
  - Medicare Shared Savings Program – (Accountable Care Organizations)

Additional market forces propel the effort through:

- Expansion of “High Value” or “Selective Networks”
- Execution of payment arrangements that cover Episodes of Care

Health Reform Continues Full Steam Ahead

Affordable Care Act Remains (Mostly) Intact After Legal, Political Challenges

Major Milestones of ACA Rollout

2012–2018

2012
Rise of Accountable Payment Models

- Medicare Advantage bonuses
- Hospital Value-Based Purchasing Program
- Medicare Shared Savings Programs
- Hospital Readmission Reduction Program
- Center for Medicare and Medicaid Innovation (CMMI)

2013
Implementation of New Financing Mechanisms

- Medicare tax increase
- Excise tax on medical devices
- Disproportionate Share Hospital (DSH) payment reductions

2014
Launch of Coverage Expansion

- Guaranteed issue
- Community rating
- Health insurance exchanges
- Individual, employer mandates
- Optional Medicaid expansion to 133% of the Federal Poverty Level (FPL)

2015-2018
Elevated Penalties for Drivers of Excess Cost

- Hospital-acquired condition penalties
- Independent Payment Advisory Board (IPAB) recommendations
- Individual, employer penalty increases
- Excise tax on “Cadillac” health plans

Source: Health Care Advisory Board interviews and analysis.

The CMS BPCI Initiative

What is the Bundled Payments for Care Improvement (BPCI) Initiative?

- A voluntary program offering providers an unprecedented opportunity to increase their accountability for specific portions of care delivered to Medicare fee-for-service beneficiaries
- Through bundled payments, hospitals, physicians, and post-acute care providers can develop shared financial accountability, securing mutual commitment to performance improvement
- 48 episode choices: Top selections are Joint replacement, Congestive heart failure, Coronary artery bypass graft, COPD; but many organizations choose all 48
- Largest voluntary Medicare payment innovation program

Model 1

Hospital Inpatient Services for All DRGs

Inpatient Payment System less discount for Part A services; physicians reimbursed on traditional fee schedule

Model 2

Hospital and Physician Inpatient and Post-Discharge Services

Retrospective bundling method: providers receive traditional FFS payments, subject to post-episode reconciliation against target price (Select inpatient DRGs)

Model 3

Post-Discharge Services Only

Retrospective bundling method: providers receive traditional FFS payments, subject to post-episode reconciliation against target price (Select inpatient DRGs)

Model 4

Hospital and Physician Inpatient Services

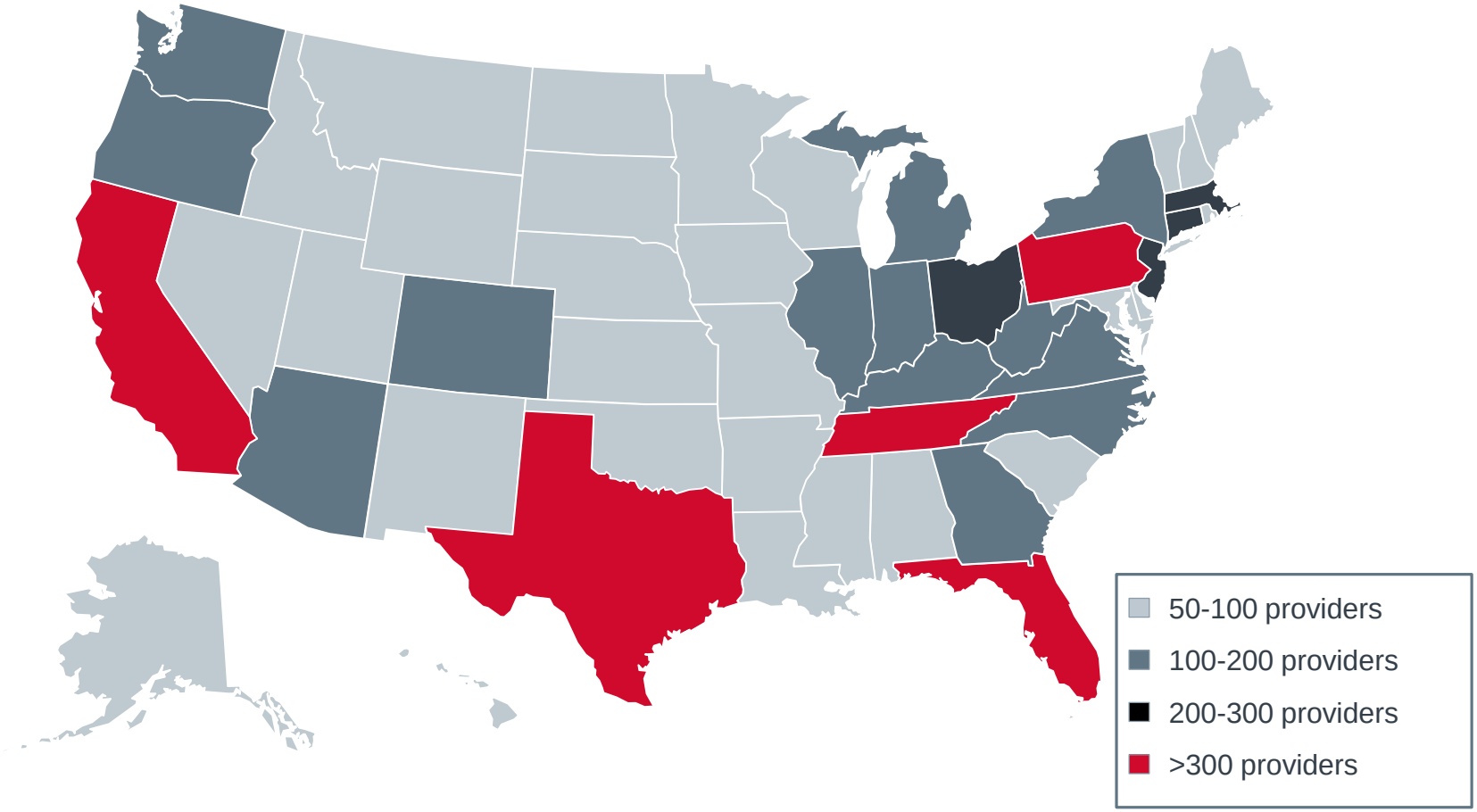
Prospective bundling method: hospital collects and distributes payments to clinicians

Over 75% of all BPCI participants have selected Models 2 or 3;
All participants in OH and TN have chosen one of these two models

Over 6,000 Providers Participating in BPCI[1]

BPCI[1] Participation by State

August 2014



1) Bundled Payments for Care Improvement.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

Further Definition of the 4 Models

	Model 1: Hospital Inpatient Services for All DRGs	Model 2: Hospital and Physician Inpatient and Post-Discharge	Model 3: Post-Discharge Services Only	Model 4: Hospital and Physician Inpatient Services
Eligible Participants	Physician groups, acute care hospitals reimbursed under IPPS[1], health systems, PHOs, conveners of providers	Model 1 participants plus post-acute care providers	Model 1 participants + post-acute providers, long-term care hospitals, inpatient rehab and home care agencies	Model 1 participants
Clinical Conditions	All Medicare DRGs	Select inpatient DRGs, proposed by applicants		
Included Services	Inpatient hospital services	Inpatient hospital and physician services; related post-acute care and readmissions	Post-acute care; related readmissions	Inpatient hospital and physician services; related readmissions
Expected Discount	Minimum increases from 0% for first six months to 2% in year 3	Minimum of 3% for 30-89 days post-discharge services; minimum 2% for 90+ days post-discharge	Proposed by applicant (no set minimum)	Minimum 3% discount (larger for DRGs in ACE[2] Demonstration)
Provider Payments	IPPS payment less discount for Part A services; physicians paid per traditional fee schedule	Retrospective bundling method: providers receive traditional fee-for-service payments, subject to post-episode reconciliation against target price		Prospective bundling method: hospital collects and distributes payments to clinicians
Quality Measures	All Hospital IQR[3] measures, plus additional measures proposed by applicants	Proposed by applicants, with CMS ultimately establishing a standardized set of metrics aligned with measures in other CMS programs		

The Patient-Centered Medical Home Defined

What is a Patient-Centered Medical Home?

- A redesigned approach to primary care that views a strengthened, long-term relationship between patient and primary care team as central to better care.
- Over 10% of primary care practices are recognized as PCMHs by the NCQA; a national quality standards agency
- Current PCMH Experience in Kentucky:
  - St. Elizabeth Healthcare – 28 Primary Care Practices operate as NCQA recognized PCMHs
  - Army Screaming Eagle PCMH: Ft. Campbell – PCMH enrollees were **67% less likely** to visit the ER (compared with standard primary care clinic enrollees)

Six Fundamental Elements

A care team that extends beyond the primary care physician

Disease registry utilization

Cross-continuum care coordination

Improved patient access

Active patient engagement

Comprehensive care delivery that involves necessary preventive care and chronic disease management

Pros:

- Improved patient satisfaction
- Improved provider and staff satisfaction
- Greater efficiencies using team-based care
- Higher quality and effectiveness of care
- Reduced ED utilization and readmissions
- Payer contracting relationships

Cons:

- Investment in technology and training can be costly and time-consuming

Source: "The Patient-Centered Medical Home's Impact on Cost and Quality" Patient-Centered Primary Care Collaborative. January 2015.; "The Future of Patient-Centered Medical Homes" NCQA 2014. Advisory Board Interviews and Analysis.

Meaningful Returns Have Proved Elusive

Many Struggling to Control Costs…

$2.26 → **$508,207**

Increased PMPM operating cost associated with 10-point increase on PCMH ranking scale[1]

Increase in annual operating costs for average primary care clinic[1]

…And Not Advancing Panel Sizes

1,950 **3,700 - 4,500**

Average national medical home panel size[2]

Panel size for best-in-class population health managers[3]

Much Harder Than Expected

"This has been a huge challenge. We are tracking over 150 quality metrics across all of our payers. Our physicians are overworked and our care managers overextended. When we started this journey, we didn't know how hard this was going to be."

Director, Primary Care Health System in the East

1) Results from a study of 669 federally funded health centers, rated on a 100-point medical home scale developed by The Commonwealth Fund.
2) Based on Advisory Board Medical Home Survey 2011.
3) Panel size at New West Physicians.

Source: Reid RJ, et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs*, 2010, 29: 834-843; Nocon RS, et al., "Association Between Patient Centered Medical Home Rating and Operating Cost at Federally Funded Health Centers," *The Journal of the American Medical Association*, July 2012, 308:60-66; Health Care Advisory Board interviews and analysis.

Evolution of "Team Based Care" Supports Transformation

Clinic Characteristics to Support Team-Based Care

- Principled behind-the-scenes workflow standardization
- Defined clinical and administrative roles
- Early physician champions
- Shared knowledge and best practices among pilots

Addressing Physician Concerns

Key Responses to Common Pushback

Fear of losing patients

- *Medical home is a physician-led team*
- *Key relationship built to maximize patient-physician interaction*

Protecting "physician-required" tasks

- *Physician-required tasks not offloaded to team*
- *"Triggers" to engage physician built into care processes*

Imposition on physician time, productivity

- *Team extends time available to patient, without additional physician time*

Cost of creating care team

- *Efficient visits improve financial performance*
- *More cost-effective to minimize physician time spent on non-physician tasks*

Goals for the Advanced Medical Home

Expanding on the Critical Elements of the Traditional Medical Home

	Traditional Medical Home	Advanced Medical Home
Care Team	• PCP-centric → RN-centric	• RN → MA, non-clinical staff • Further prioritization of PCP time to complex primary care cases
Practice	• Team huddle	• Streamlined EMR workflows
Patient Experience	• Health coaching • Proactive outreach	• Reduced patient idle time • Improved access, virtual contact
Model Goal	• Stabilize primary care • Improve quality	• Increase capacity • Improve quality; decrease costs

Source: Health Care Advisory Board interviews and analysis.

Overview – MSSP Accountable Care Organization (ACO)

What is a Medicare Shared Savings Program (MSSP) ACO?

- The Medicare Shared Savings Program is a ***value-based*** contract being offered for Medicare FFS patients that allows eligible groups of healthcare providers to share in any savings generated by the provision of coordinated, high quality and low cost healthcare.
- Lays the ***foundation*** for participation in other value-based reimbursement (commercial, self-insured, Managed Medicaid, etc.)
- CMS defines an ACO as a provider-led organization with a strong base of primary care that is collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients

Imperative Strategies for Success

An aligned physician network, with physicians integrated either through CI or extensive employment

An IT infrastructure that facilitates exchange of patient information and identification of care improvement opportunities

An optimal capacity strategy, including a streamlined acute care enterprise and a comprehensive ambulatory network

Transformed clinical operations, including standardized care pathways, emphasis on primary care, smooth care transitions, and patient activation

Partnerships with payers willing to collectively reward all participants for better population management (e.g., payment bundles, shared-savings, global risk)

Pros:

- Improved quality outcomes
- Reduced health care expenditures
- Improved communication and workflow
- Potential financial gain

Cons:

- Moving too quickly without the necessary infrastructure to support the model
- Lack of alignment with payer contracting strategy

Mechanics of the MSSP Model

Applying Total Cost Accountability to Fee-for-Service Payments

Program in Brief: Medicare Shared Savings Program

- Cohorts launched April 2012, July 2012, and January 2013; contracts to last minimum of three years
- Physician groups and hospitals eligible to participate, but primary care physicians must be included in any ACO group
- Participating ACOs must serve at least 5,000 Medicare beneficiaries
- Bonus potential depends on Medicare cost savings, quality metrics
- Two payment models available: one with no downside risk, the second with downside risk in all three years

Shared Savings Payment Cycle

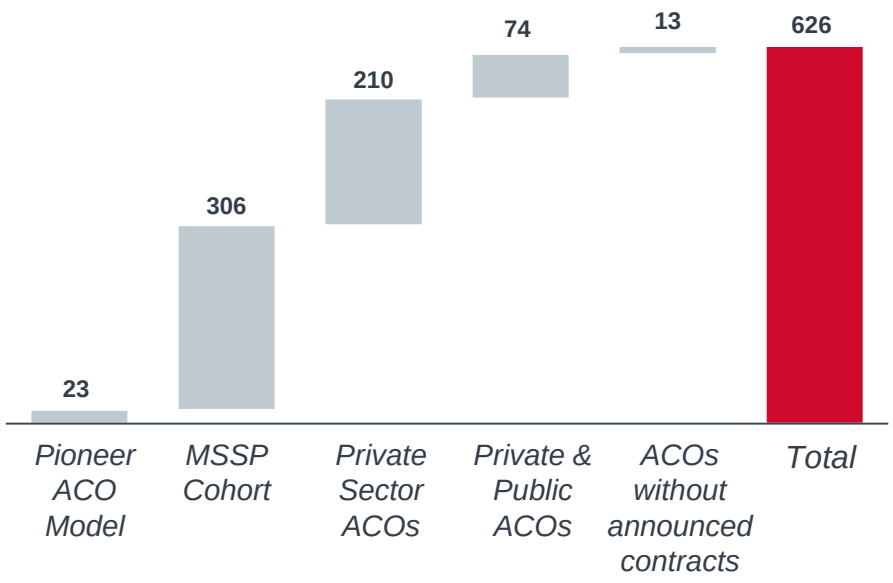
1. **Assignment**
   Patients assigned to ACO based on terms of contract
2. **Billing**
   Providers bill normally, receive standard fee-for-service payments
3. **Comparison**
   Total cost of care for assigned population compared to risk-adjusted target expenditures
4. **Shared Savings Payment**
   Bonuses or penalties levied based on variance of expenditures from target
5. **Distribution**
   ACO responsible for dividing bonus payments among stakeholders

Source: Health Care Advisory Board interviews and analysis.

Number of ACOs Continues to Grow

Total Number of Operating ACOs

May 2014



Widening Reach of ACOs[1]

67%	Portion of U.S. population living in a primary care service area with an ACO
17%	Portion of U.S. population treated by an ACO
5.3M	Medicare FFS beneficiaries treated by an ACO

1) As of April 2014.

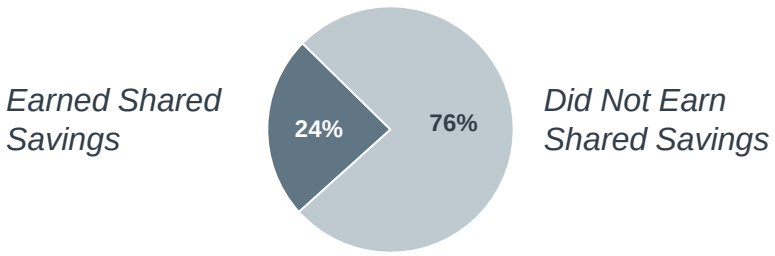
Source: Oliver Wyman, "ACO Update: Accountable Care at a Tipping Point," April 2014; Leavitt Partners, "Growth and Dispersion of ACOs," June 2014; Marketing and Planning Leadership Council interviews and analysis.

Financially, Medicare ACOs Yielding Mixed Results

But Clinical Quality Trending Upward

Shared Savings Bonus Distribution Among MSSP ACOs

2012 and 2013 Cohorts



Reducing Participation

"We are continuing to reduce the size and scope of our investments to focus on those ACOs where the [shared savings] program can work and we can truly impact the cost and quality of medical care."

Richard Barasch, CEO, Universal American

First Year Pioneer ACO Results

32
Successfully reported quality measures

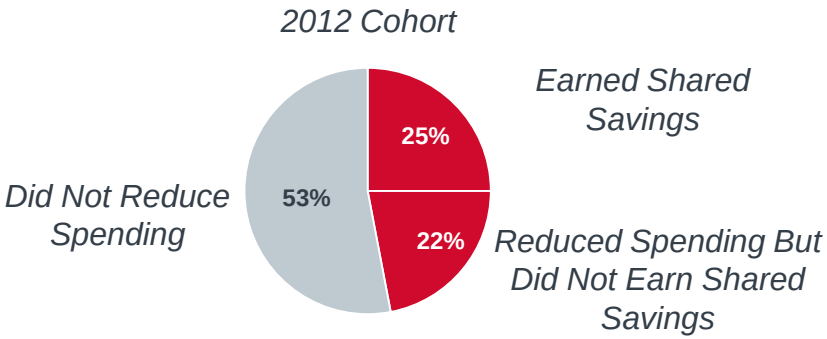
25
Generated lower risk-adjusted readmission rates

Source: Center for Medicare and Medicaid Services, "Fact sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth," Available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html;Health Care Advisory Board interviews and analysis.

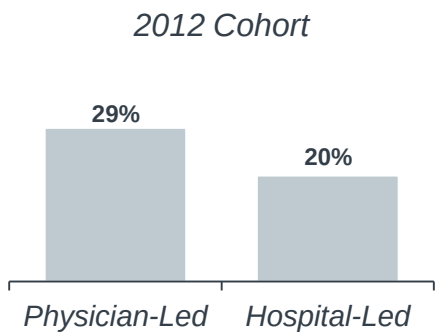
Starting to See Early Adopters Move the Dial

Physician-Led ACOs More Likely to Generate Savings

First-Year Spending Reduction By MSSP[1] ACOs



Percent of MSSP ACOs that Earned Shared Savings by Sponsorship



$126M
Shared savings earned by 2012 MSSP ACOs in first year

$147M
Total cost savings by Pioneer ACOs in first year

1) Medicare Shared Savings Program.

Source: Muhlestein D, "Accountable Care Growth in 2014: A Look Ahead," Health Affairs Blog, January 29, 2014, available at: www.healthaffairs.com/blog; CMS, "More Partnerships Between Doctors and Hospitals Strengthen Coordinated Care for Medicare Beneficiaries," December 23, 2013; Oliver Wyman, "Accountable Care Organizations Now Serve 14% of Americans," February 19, 2013; Health Care Advisory Board interviews and analysis.

A Number of Non-Financial Reasons to Sign Up

For Some, MSSP Not Only About Financial Sustainability

Strategic Reasons for MSSP Participation

Increased physician alignment

Provides opportunity to reward physicians for increased alignment with health system's population health goals

Strengthened impetus for population health infrastructure development

Generates strong rationale to increase investment in infrastructure required by risk-based contracts

Enhanced care management, development

Presents opportunity to learn, experiment with the clinical, administrative requirements of population health, risk-based contracting

Intensified cultural change

Introduces need for provider to begin focusing more closely on population health across entire organization

Source: Health Care Advisory Board interviews and analysis.

Defining and Contracting for Episodes of Care

The Tennessee Definition

Patients seek care and select providers as they do today

Providers submit claims as they do today

Payers reimburse for all services as they do today

"Quarterbacks" are provided detailed information for each episode which includes actionable data

Also receive quarterly reports showing underlying costs and quality indicators for their episodes

- Quality thresholds achieved with scores and comparison to other providers and gain share standard
- Key utilization statistics
- Total number of episodes
- Cost comparison to other providers and gain and risk sharing thresholds

"Quarterbacks" are financially rewarded for high quality and efficient care. They share in the savings they create, or in any excess cost they incur

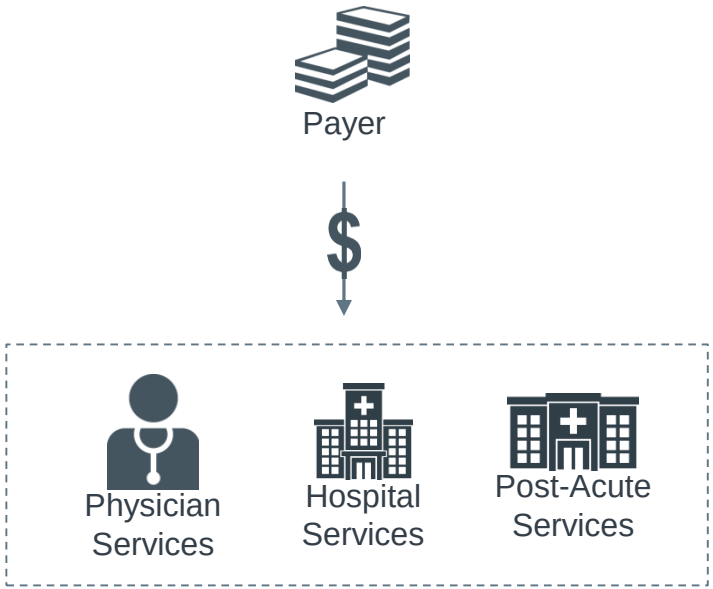
- Acute Asthma Exacerbation
- Perinatal
- Total Joint Replacement (Hip and Knee)
- Acute COPD Exacerbation
- Screening and surveillance colonoscopy
- Acute PCI
- Non-acute PCI

Redefining the Acute Care Episode

Bundled Payments Drive Delivery System Integration

Bundled Payment Framework

Lump Sum Payments Drive Integration Through Shared Accountability



Program in Brief: Medicare's Bundled Payments for Care Improvement

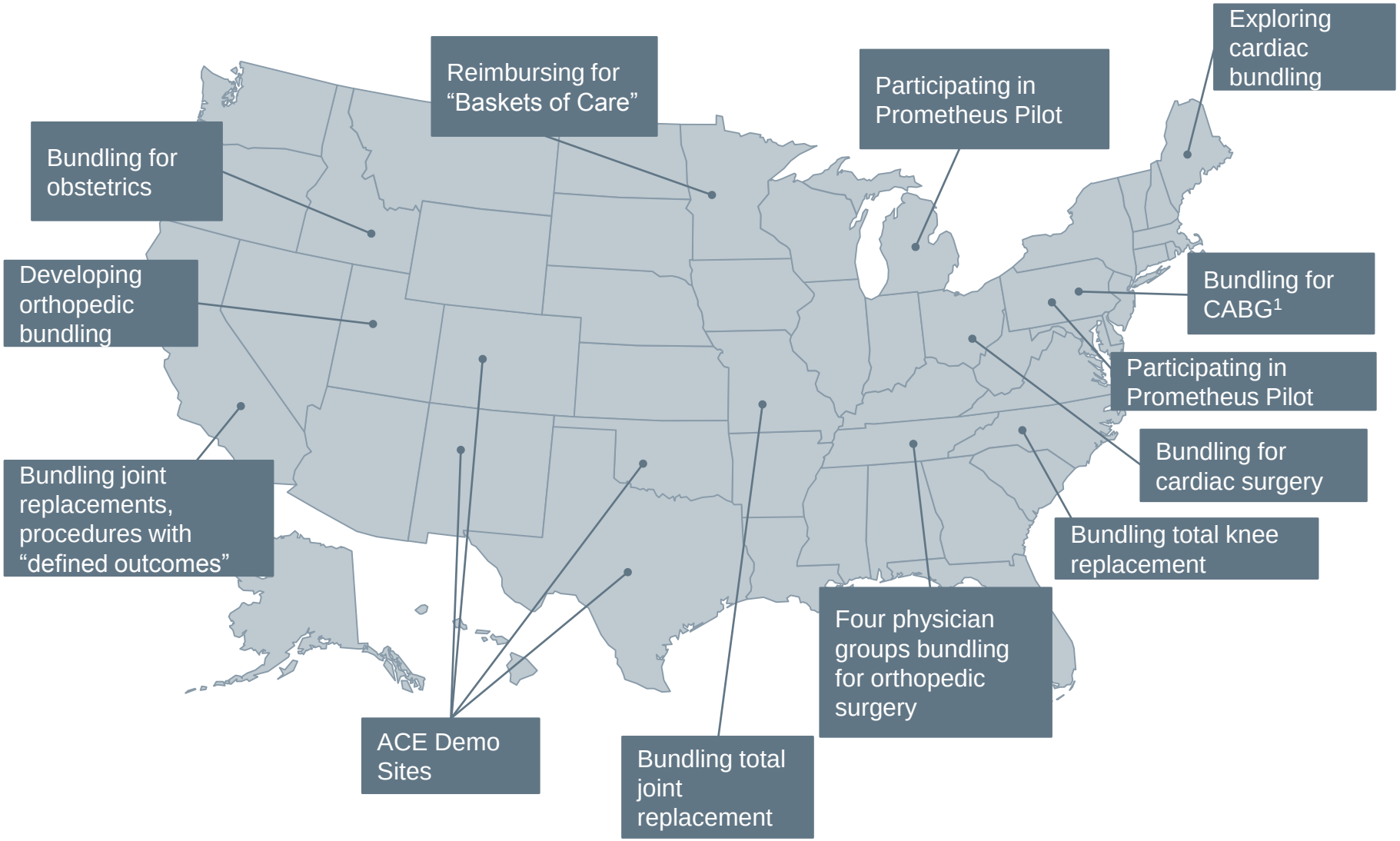
- CMMI[1] initiative offering four voluntary bundled payment models; more than 450 providers selected to participate
- Models 1-3 provide retrospective reimbursement; Models 2 and 3 include post-episode reconciliation; Model 4 offers single prospective payment
- Acute care hospitals, physician groups, health systems eligible for all models; post-acute facilities may participate without hospitals in Model 3
- Physicians eligible for gainsharing bonuses up to 50 percent of traditional fee schedule
- For all models, applicants must propose quality measures, which CMS will use to develop set of standardized metrics

1) Center for Medicare and Medicaid Innovation.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

Not Just a Medicare Program

Private Sector Bundling Pilots Emerging Nationwide

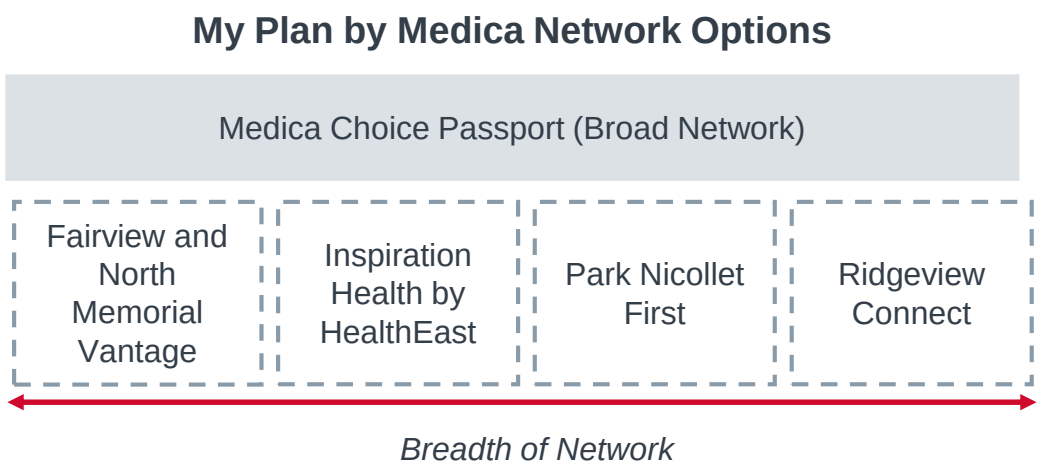


1) Coronary Artery Bypass Graft.

Source: Health Care Advisory Board interviews and analysis.

Exclusive/Selective Networks Compete on Premiums

Signaling Ability to Control Total Costs



8%

Average premium savings for choosing ACO network

33%

Average savings to employee for choosing ACO network, after accounting for employer contribution

Case in Brief: My Plan by Medica

- Defined contribution health plan offered by Medica, a 1.5 million-member health plan based in Minnetonka, Minnesota
- Allows employees to choose from a broad network or one of four ACO narrow networks
- Private exchange platform powered by Bloom Health

Source: Anderson J, "Medica Partners With Four Diverse ACOs On Unique Private Health Exchange Model," AIS Health, October 12, 2012, available at: www.aishealth.com; Health Care Advisory Board interviews and analysis.

Driving A "Commitment Device" for Cost Control

Regulators Demand Cost Improvements through Selective Network Arrangements

Components of Partners HealthCare Agreement with State of Massachusetts

Comprehensive Total Cost Cap

Partners' total network cost cannot exceed the rate of general inflation through 2020

Component Contracting

Payers are allowed to contract with Partners providers separately for 7-10 years

Restriction on Physician Joint Contracting

Partners cannot joint contract on behalf of non-owned physician group affiliates

Hospital, Physician Growth Restriction

Partners faces restrictions on adding new hospitals for 7 years; physicians for 5 years

Case in Brief: Partners HealthCare

- 9-hospital, not-for-profit health system based in Boston, Massachusetts
- In May 2014, reached agreement with the state of Massachusetts to limits to cost growth, joint contracting, physician growth, and hospital expansion for 7 to 10 years in return for purchasing South Shore and Hallmark hospitals

Source: Attorney General of Massachusetts, "AG Coakley Reaches Agreement in Principle with Partners HealthCare," May 19, 2014, available at: www.mass.gov; Health Care Advisory Board interviews and analysis.

Employers Entering Into Direct Provider Contracts

Key Components of Partnership

Narrowing of Health Plan Options
Intel reducing number of health plan options from 8 to 4; two remaining plans are narrow networks of PHS[1] providers

Shared Accountability
Upside and downside risk for health care spending compared to projected target

Customized Care Offerings
Addition of depression screening into customary provider workflow

Infrastructure for Care Management
Conversion of Intel's on-site clinic into full service patient-centered medical home

5,400	Covered lives in contract
$8-10M	Projected savings through contract, 2013-2017

Case in Brief: Intel Corporation

- Large, multinational employer headquartered in Santa Clara, California
- Entered into narrow-network contract with Presbyterian Healthcare Services, an 8-hospital system in New Mexico, for employees at Rio Rancho plant

Source: Intel Corporation, "Employer-Led Innovation for Healthcare Delivery and Payment Reform: Intel Corporation and Presbyterian Healthcare Services," Santa Clara, California; Evans M, "Slimming Options," Modern Healthcare, July 13, 2013, available at: www.modernhealthcare.com; Health Care Advisory Board interviews and analysis.

1) Presbyterian Healthcare Services.

"Sustainable Growth Rate" (SGR) and Impact to Physicians

- Permanent repeal of the SGR will dramatically alter Medicare payments to physicians

- The "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA) will significantly accelerate Medicare's shift toward value-based payments for physicians

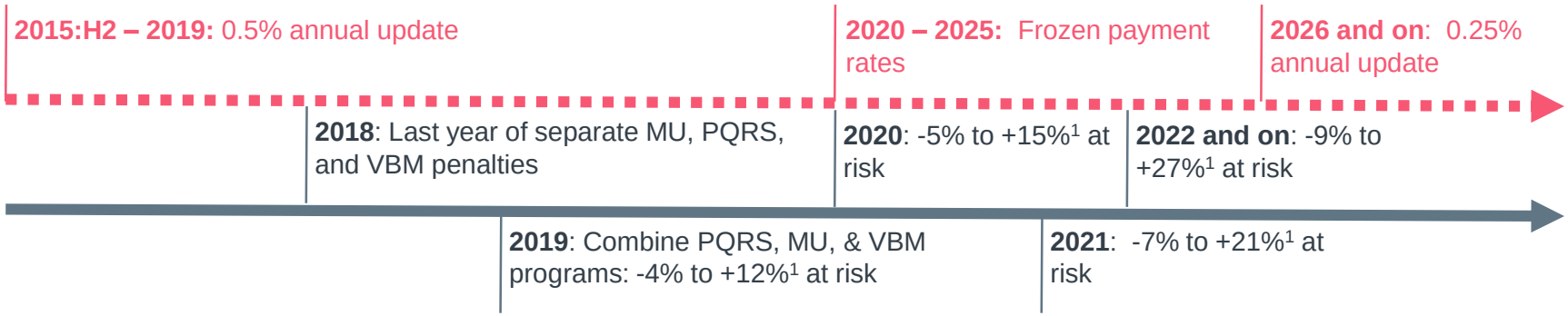
- MACRA introduces two value based payment "tracks" for physicians
  - **The Merit-Based Incentive Payment System -** MACRA consolidates and expands pay-for-performance incentives within the fee-for-service system, creating the new Merit-Based Incentive Payment System (MIPS). Under MIPS, the Physician Quality Reporting System (PQRS), EHR Incentive Program, and Physician Value-Based Modifier become part of a single payment adjustment to physician payments beginning in 2019.

  - **The Alternative Payment Models Track -** MACRA allows providers participating in "Alternative Payment Models" (APMs) to opt out of MIPS if providers meet increasing thresholds for the percentage of their revenue they receive through qualifying financial risk arrangements under the APMs.

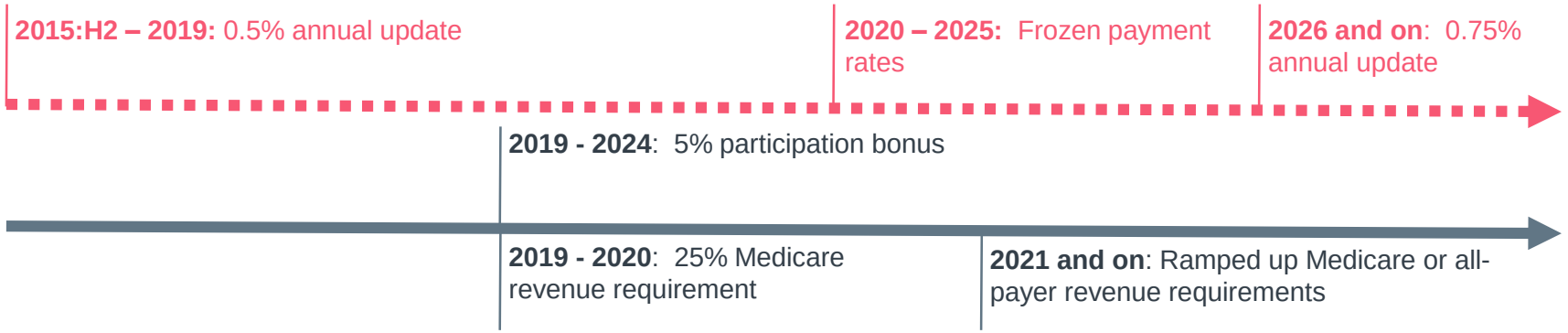
SGR Repeal Creates Two Tracks for Providers

Providers Must Choose Enhanced FFS[1] or Accountable Care Options

Merit-Based Incentive Payment System



Advanced Alternative Payment Models[2]



1. Fee for service.
2. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
3. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

Source: *The Medicare Access and CHIP Reauthorization Act of 2015*; Advisory Board analysis.

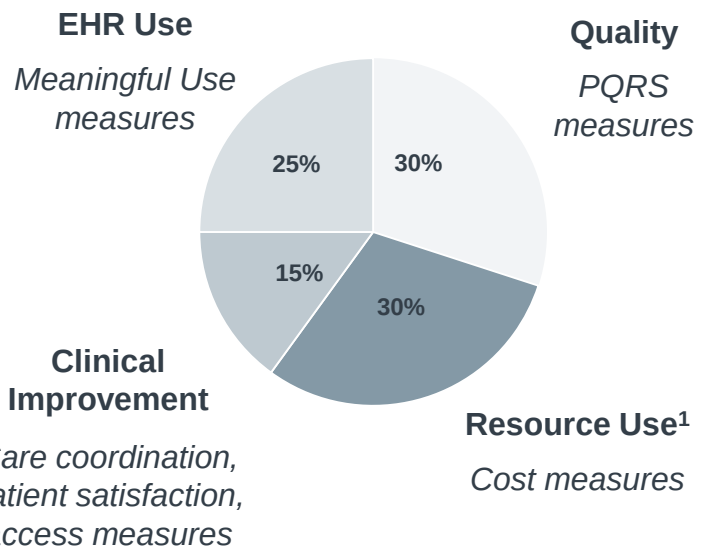
New Law Strengthens Move to P4P Incentives

Builds on Trend of Increasing Provider Accountability Even within FFS

Merit-Based Incentive Payment System (MIPS) Summary

- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019
- Applies to physicians, NPs, clinical nurse specialists, physician assistants, and certified RN anesthetists
- Includes improvement incentives for quality and resource use categories

MIPS Performance Category Weights



1) Resource Use measures would be weighted less during first two years of MIPS program, reaching 30 percent in the third year of the program. Quality measures would be weighted more than 30 percent during the first two years to make up the difference.

Source: *The Medicare Access and CHIP Reauthorization Act of 2015*; Advisory Board analysis.

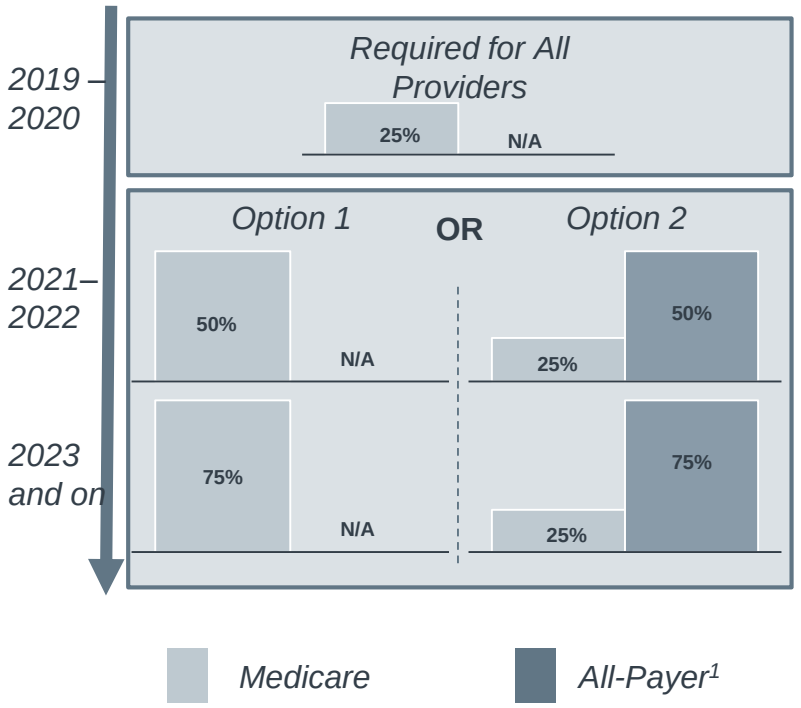
APM Bonus Rewards Participation in New Models

Option Signals Policymakers' High Expectations for Risk-Based Models

Advanced Alternative Payment Model (APM) Summary

- Requires significant share of provider revenue in APM with two-sided risk, and quality measurement; or in some cases participation in certified patient-centered medical homes (PCMHs)
- Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS requirements
- Includes partial qualifying mechanism that allows providers that fall short of APM requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS

Required Percentage of Revenue Under Risk-Based Payment Models



1) Risk-based contracts with Medicare Advantage plans count toward the all-payer requirement category.

Source: *The Medicare Access and CHIP Reauthorization Act of 2015*; Advisory Board analysis.

Overview of Accountable Payment Models

Key Attributes	Value-Based Purchasing	Bundled Payments	Accountable Care Organizations (ACOs)
Definition	Pay-for-performance program differentially rewards or punishes hospitals (and likely ASCs and physicians in coming years) based on performance against predefined process and outcomes performance measures	Purchaser disburses single payment to cover certain combination of hospital, physician, post-acute, or other services performed during an inpatient stay or across an episode of care; providers propose discounts, can gain share on any money saved	Network of providers collectively accountable for the total cost and quality of care for a population of patients; ACOs are reimbursed through total cost payment structures, such as the shared savings model or capitation
Purpose	Create material link between reimbursement and clinical quality, patient satisfaction scores	Incent multiple types of providers to coordinate care, reduce expenses associated with care episodes	Reward providers for reducing total cost of care for patients through prevention, disease management, coordination
Advisory Board Assessment	Withhold-earn back model will put significant dollars at risk for all providers, force immediate focus on quality and experience metrics	Increases accountability for cost and quality within episodes of care without removing FFS volume incentive; new lever for financial alignment between independent specialists and hospitals	Long-range goal of CMS to migrate to risk contracting; will spark industry-wide investment in primary care infrastructure to establish narrower networks
Role of CMMI[1]	Dedicating $500M to Partnership for Patients, targeting hospital-acquired infections, readmissions	Accepting providers' proposals to test four different bundled payment models, including one without inpatient care	Accepting providers' proposals to test various payment systems, including both shared savings and partial capitation

1) Center for Medicare and Medicaid Innovation.

Source: Marketing and Planning Leadership Council interviews and analysis.

Questions, Discussion and Answers

April Workgroup Meetings: Recap and Report Out

Integrated and Coordinated Care Workgroup

The Integrated and Coordinated Care workgroup identified strategies to support the implementation of three types of care delivery system models: Patient Centered Medical Homes (PCMHs), Accountable Care Organizations (ACOs), and Health Homes.

Patient-Centered Medical Home

- Encourage the co-location of providers
- Increase the use of telehealth as a way of increasing patient visits
- Educate physicians about the importance of conducting oral health screenings

Accountable Care Organization

- Encourage coordination of providers both within and outside ACOs
- Reduce the lag in reconciliation for ACOs
- Use technology, such as telehealth, in oral health care
- Partner with existing agencies, such as the Department of Education, to improve data sharing

Health Home

- Develop person-centered care plans for both physical and behavioral health
- Make care plans available to the entire care team via a common portal

Expand the care team

Engage community resources in care coordination

Care Team

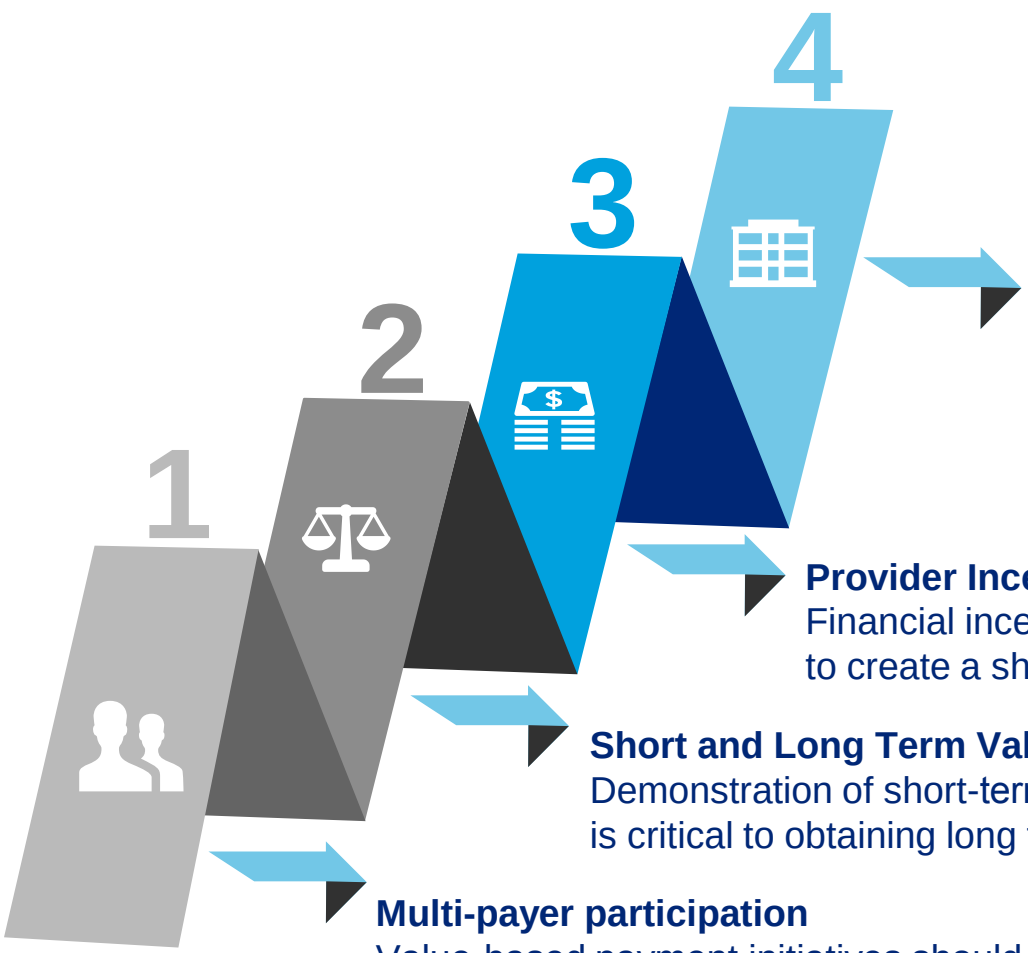
- Oral Health
- Public Health
- Schools
- Pharmacists,
- Physical Therapists,
- Community Health Workers (CHWs)
- Community Mental Health Centers (CMHCs)

Community Resources

- Faith Communities
- Housing Programs
- Grocery Stores
- Support Groups

Payment Reform Workgroup

The Payment Reform workgroup established goals for value-based payment reform as part of the SIM Model Design.



Understand Current Landscape
Provider change readiness assessments and leveraging existing initiatives, such as those used by some hospitals, should be considered when developing a payment reform strategy.

Provider Incentives
Financial incentives to providers are an effective way to create a shift in the payment landscape.

Short and Long Term Value
Demonstration of short-term value via “quick wins” is critical to obtaining long term buy in.

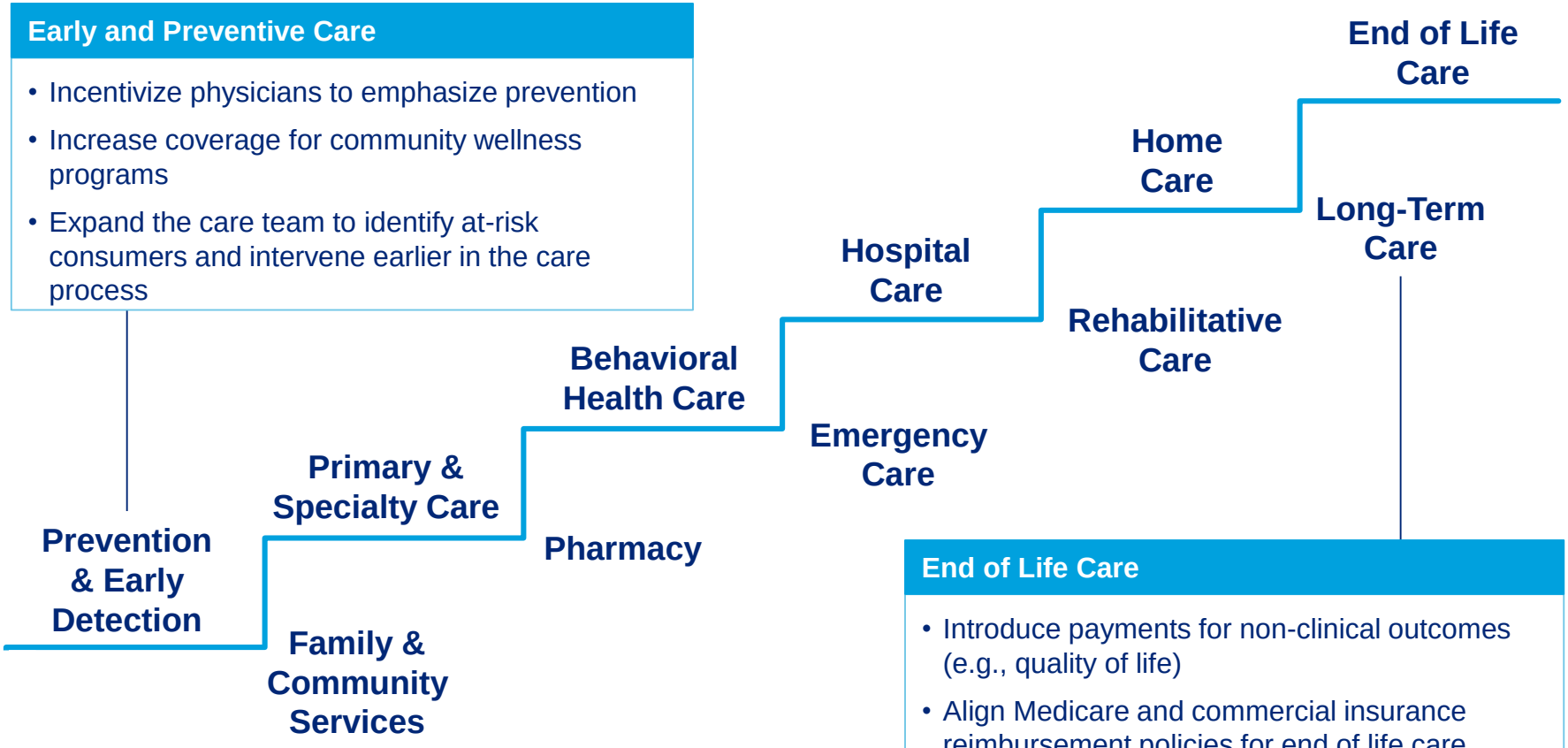
Multi-payer participation
Value-based payment initiatives should encompass multiple payers across the care continuum.

Payment Reform Workgroup

The Payment Reform workgroup identified opportunities for payment reform across the care continuum, including preventive and end of life care.

Early and Preventive Care

- Incentivize physicians to emphasize prevention
- Increase coverage for community wellness programs
- Expand the care team to identify at-risk consumers and intervene earlier in the care process



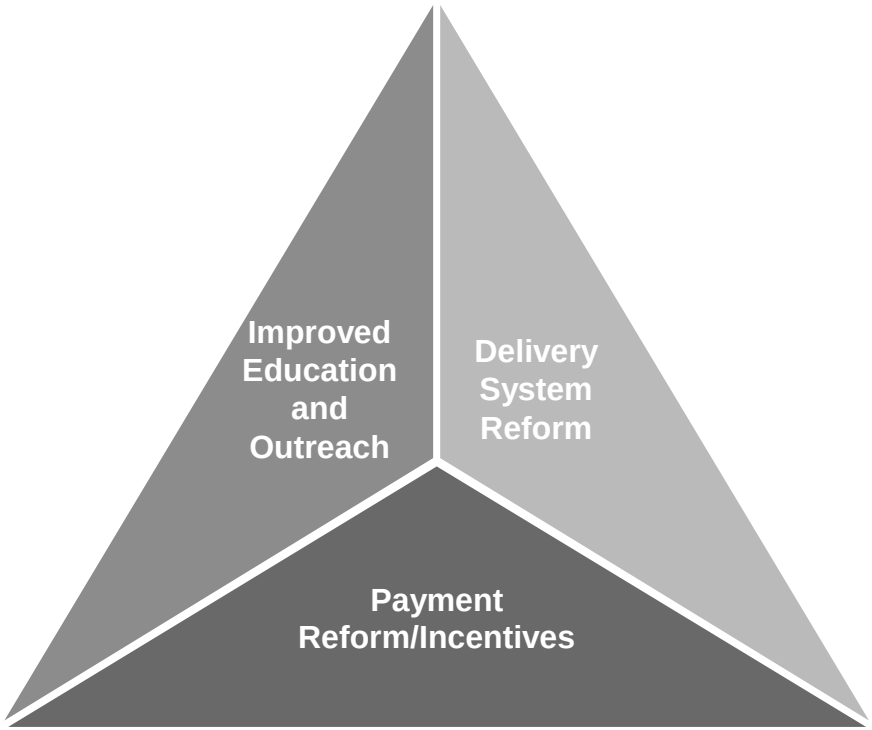
End of Life Care

- Introduce payments for non-clinical outcomes (e.g., quality of life)
- Align Medicare and commercial insurance reimbursement policies for end of life care
- Increase earlier referrals from long term care to hospice

Increased Access Workgroup

The Increased Access workgroup focused on urban delivery challenges, and identified strategies to overcome barriers to these challenges.

Components of Urban Access Reform



Enabling Technology

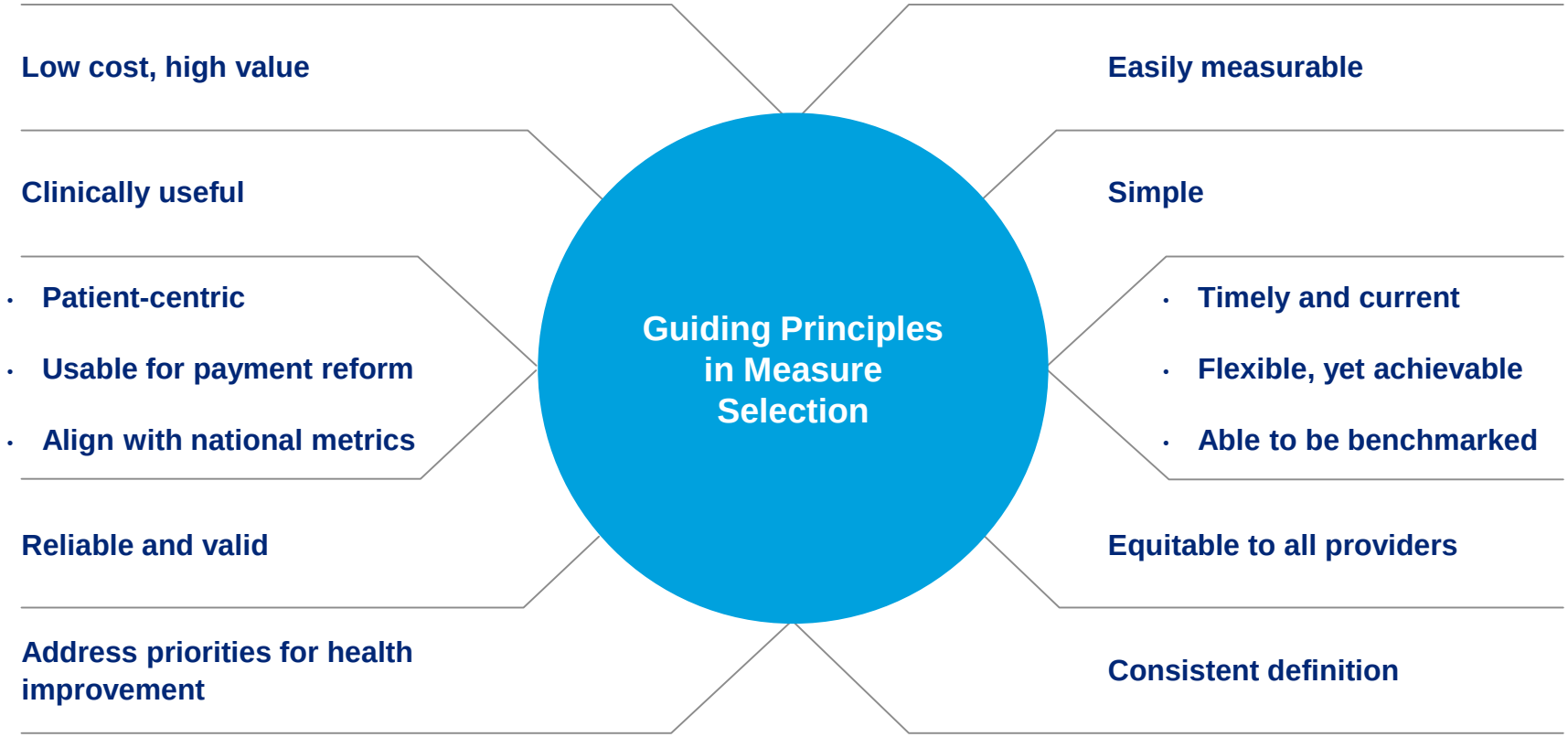
- Improve diagnostic and preventive care through the use of telehealth
- Identify “access points” for collecting data (e.g., consumer wearables, school records)
- Develop a standards-based approach to technology adoption that is equitable to providers across the care continuum

Strategies for Overcoming Urban Access Challenges

- Improve Education and Outreach
  - Increase health education/awareness through community organizations and worksites
  - Increase education about the relationship between oral and physical health
- Delivery System Reform
  - Improve patient access to care by colocating services and integrating practices
- Payment Reform/Incentives
  - Increase reimbursement and adopt policies to encourage Medicaid patient acceptance
  - Develop payment strategies that support the expansion of the behavioral health system

Quality Strategy/Metrics Workgroup

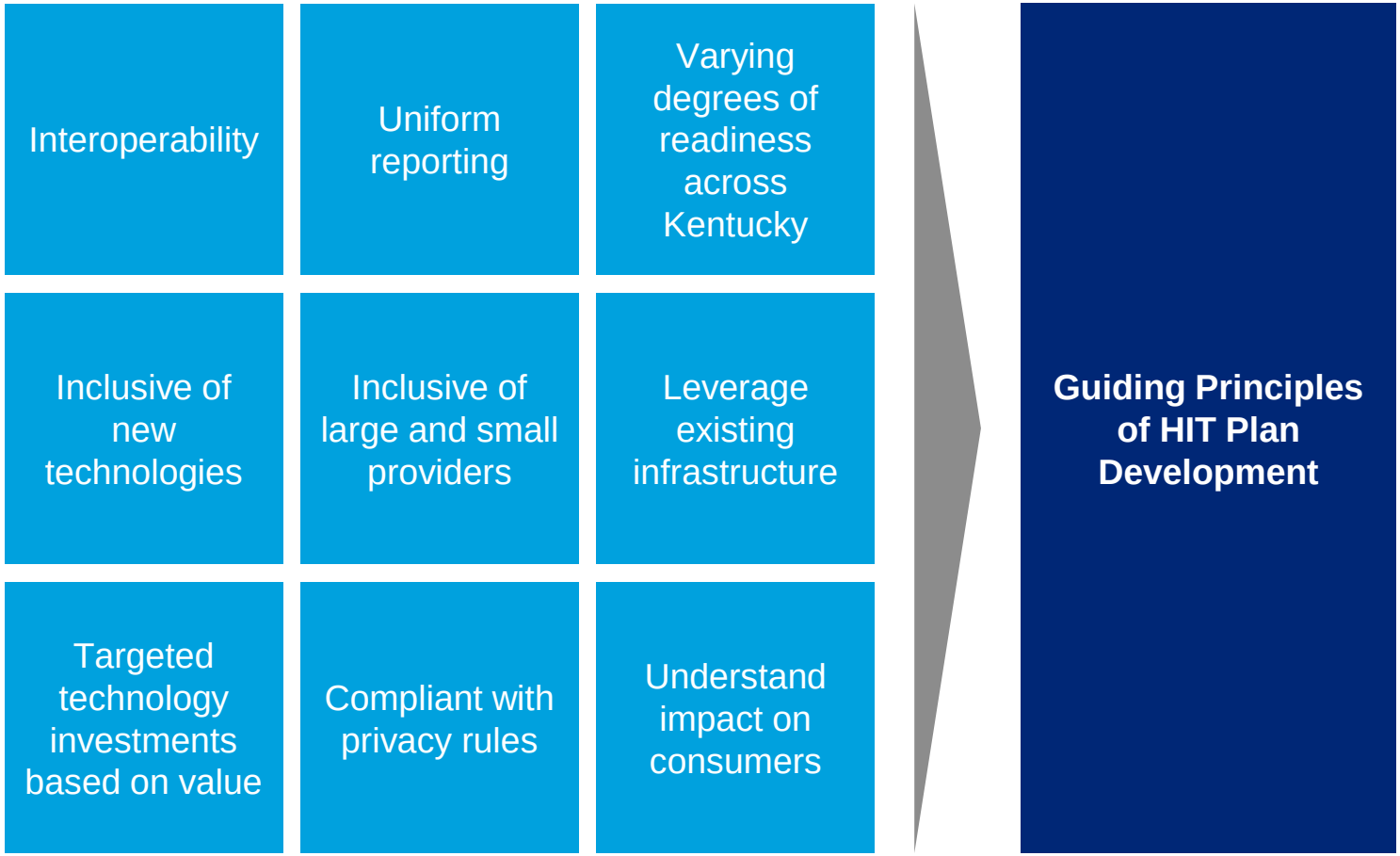
The Quality Strategy/Metrics workgroup discussed the guiding principles for selecting quality measures, which will lay the foundation for selecting quality measures as part of the SIM initiative.



These principles will be used in selecting the core set of quality measures that will be part of the final Model Design.

HIT Infrastructure Workgroup

After reviewing the health information technology (HIT) plans from other SIM states, the HIT Infrastructure workgroup developed a set of guiding principles to consider when developing the HIT plan for SIM.



Population Health Improvement Plan (PHIP) Draft Overview

PHIP Status Update and Process Overview

CMS has created a project structure that promotes crafting the Population Health Improvement Plan (PHIP) **prior** to developing payment and service delivery reforms with a **first draft due on May 29, 2015**.

PHIP Development Process:

May Draft PHIP		December Final PHIP
Health Needs Assessment	→	Interventions to Improve Population Health
Current Population Health Initiatives	→	Implementation Plan
Stakeholder Engagement Plan	→	Governance Framework

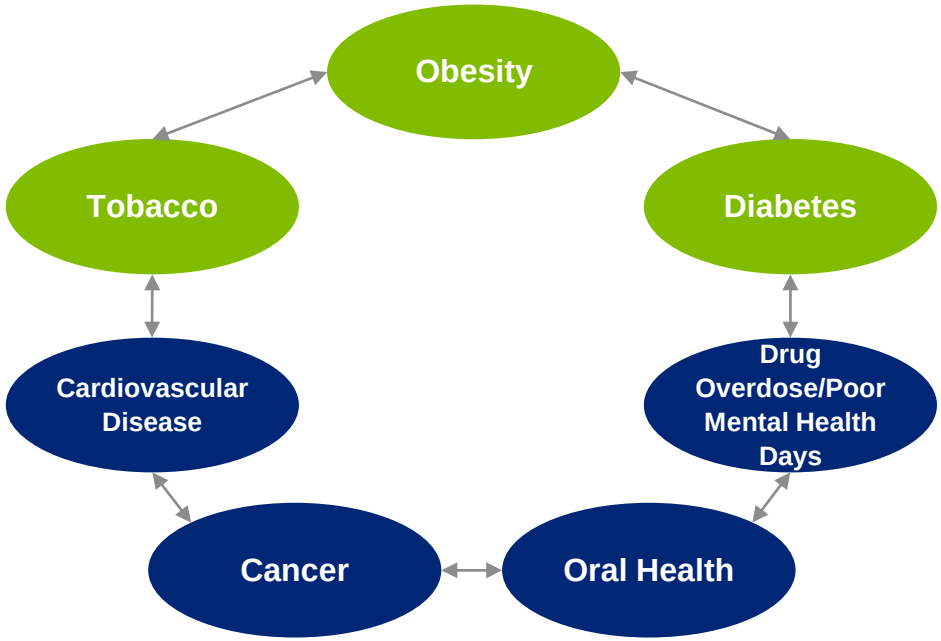
The **May draft of the PHIP** will serve as a **checkpoint** on the unique population health needs that Kentucky is facing, and as **a mechanism to solicit stakeholder input** throughout the remainder of the Model Design process on how to **design payment and service delivery reforms** around these population health needs.

PHIP Section 1: Health Needs Assessment

The draft PHIP contains a health needs assessment for the three CMS/CDC prescribed population health focus areas, plus the additional four focus areas added to promote the PHIP's alignment with and as an extension of **kyhealthnow**.

Health Needs Assessment Outline

- The PHIP draft provides an **initial assessment** of the **gaps in access to care and the health status disparities** that Kentucky seeks to address in the delivery system transformation initiatives designed over the course of the Model Design period.
- For each of the seven population health focus areas, the PHIP describes the current state and its impact on the Commonwealth and its populations, focusing specifically on:
  - **The prevalence of the condition**
  - **The disproportionate populations at risk**
  - **The economic impact**



CMS/CDC & kyhealthnow Focus Areas

Other kyhealthnow Focus Areas

PHIP Section 2: Current Health Initiatives

The second section of the PHIP focuses on describing major ongoing population health-focused initiatives to improve both health outcomes and risk-factors related behavior. While the connection between the PHIP and **kyhealthnow** is inherent throughout, the PHIP describes the work being done in other areas and how stakeholders are playing multiple roles in each.

kyhealthnow

- **kyhealthnow** established seven health goals for the Commonwealth, along with a number of specific strategies to help achieve these goals through 2019.
- These strategies will be implemented through executive and legislative actions and public-private partnerships.
- In addition, an **Oversight Team** was established to monitor and provide oversight of the administration's efforts to meet the kyhealthnow goals and carry out the strategies needed to achieve these goals, which is attached to CHFS.
- The PHIP is using **kyhealthnow** and its goals as its framework to develop new payment and delivery system reforms that work towards reaching each identified goal and a new governance process to provide long term monitoring and oversight.

ER "Super-Utilizer" Initiative

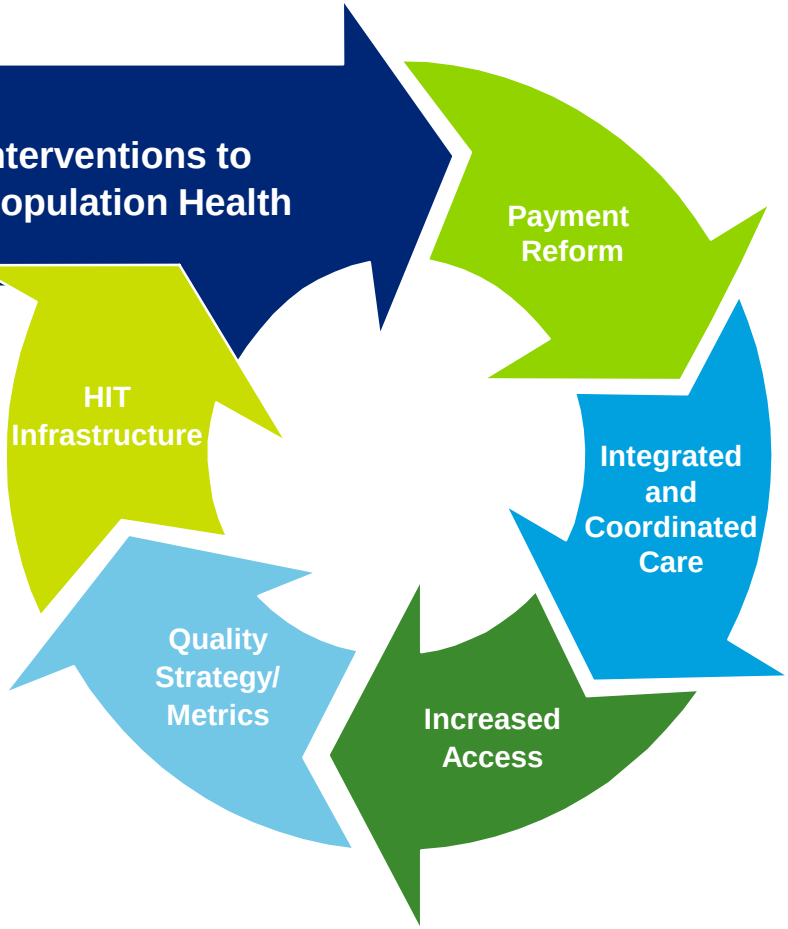
- Kentucky was awarded participation in a National Governor's Association (NGA) Policy Academy to address **emergency department (ED) super-utilization** in July 2013 and expanded the program statewide in August 2014.
- **Phase I** of the project focused on evaluating, recommending, and implementing models that efficiently navigate patients, focusing on decreasing emergency room super-utilization.
- **16 hospital sites** participated in Phase I of the project, and these sites are already seeing success, including active partner engagement and the development of new tools to monitor super-utilization data.
- The **Kentucky Department for Public Health (DPH)** provides assistance to these hospital sites through workgroup conference calls, data analysis, and specific technical expertise.

Unbridled Health

- The Coordinated Chronic Disease Prevention and Health Promotion Plan, or **Unbridled Health**, was completed in August 2013 through the work of more than an 80 member steering committee, a committee that continues to meet on an annual basis to identify synergies around the key initiatives included in the plan.
- **Unbridled Health** provides a framework in which organizations and individuals can unite as one powerful force to reduce the significant chronic disease burden in our state.
- **The framework** includes policy, systems and environmental changes that support healthy choices; expanded access to health screenings and self-management programs; strong linkages among community networks; and research data that are used as a catalyst for change.

PHIP Section 3: Stakeholder Engagement

Throughout the Model Design period, CHFS will use a robust, iterative process with internal and external stakeholders to craft the components of the Model Design, the first component being the PHIP. The team has developed a formal stakeholder engagement approach that will be used to develop the strategies and interventions for future inclusion in the PHIP.



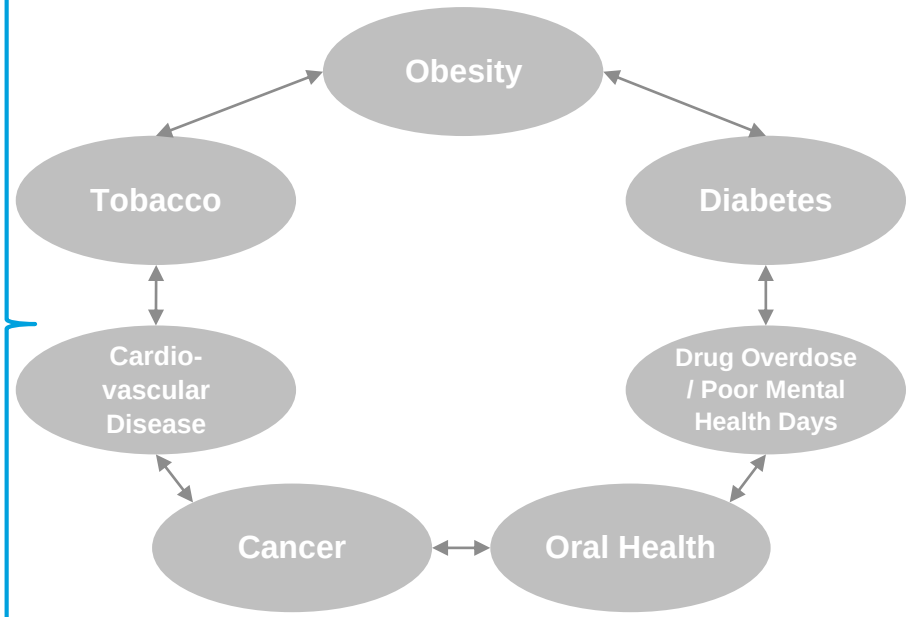
Stakeholder Process

- The development of the final PHIP will involve continuous stakeholder input and involvement at every step of the process across all health system sectors.
- The workgroups have been organized by topic area in order to align with the way in which components of the Model Design must be developed; workgroups will participate in discussions around the interventions included in the PHIP.
- Input by stakeholder workgroups, followed by broad-based report out in the large stakeholder meeting setting, will cultivate and maintain lasting stakeholder support for the PHIP's reforms and interventions.

PHIP Section 4: Interventions to Improve Population Health

Using the health needs assessment and population health focus areas of kyhealthnow, stakeholders will develop interventions to improve population health in the context of the SIM workgroups and their topic areas over the course of the Model Design process.

1. Service Delivery Model Options
2. Payment Methodologies
3. Policy and Regulatory Levers
4. Workforce Needs Assessment
5. Health Information Technology



These categories of interventions to improve population health and how they apply to the seven focus areas are not comprehensive and lend themselves to expansion, refinement, and discussion with all SIM stakeholders.

Next Steps for the Draft PHIP

In May, SIM stakeholders attending one or more workgroup will contribute to the development of the draft PHIP. Each workgroup will recap the initial work done in March in identifying drivers to improving population health, and will use this as a framework to develop guiding principles for developing future interventions in the workgroup's respective area.

May Workgroups

1. **Discuss the impact of the draft PHIP on the workgroup and its charter**
2. **Recap outputs generated from driver diagram exercise completed in March**
3. **Document guiding principles for developing reforms that align to PHIP goals**

May 2015

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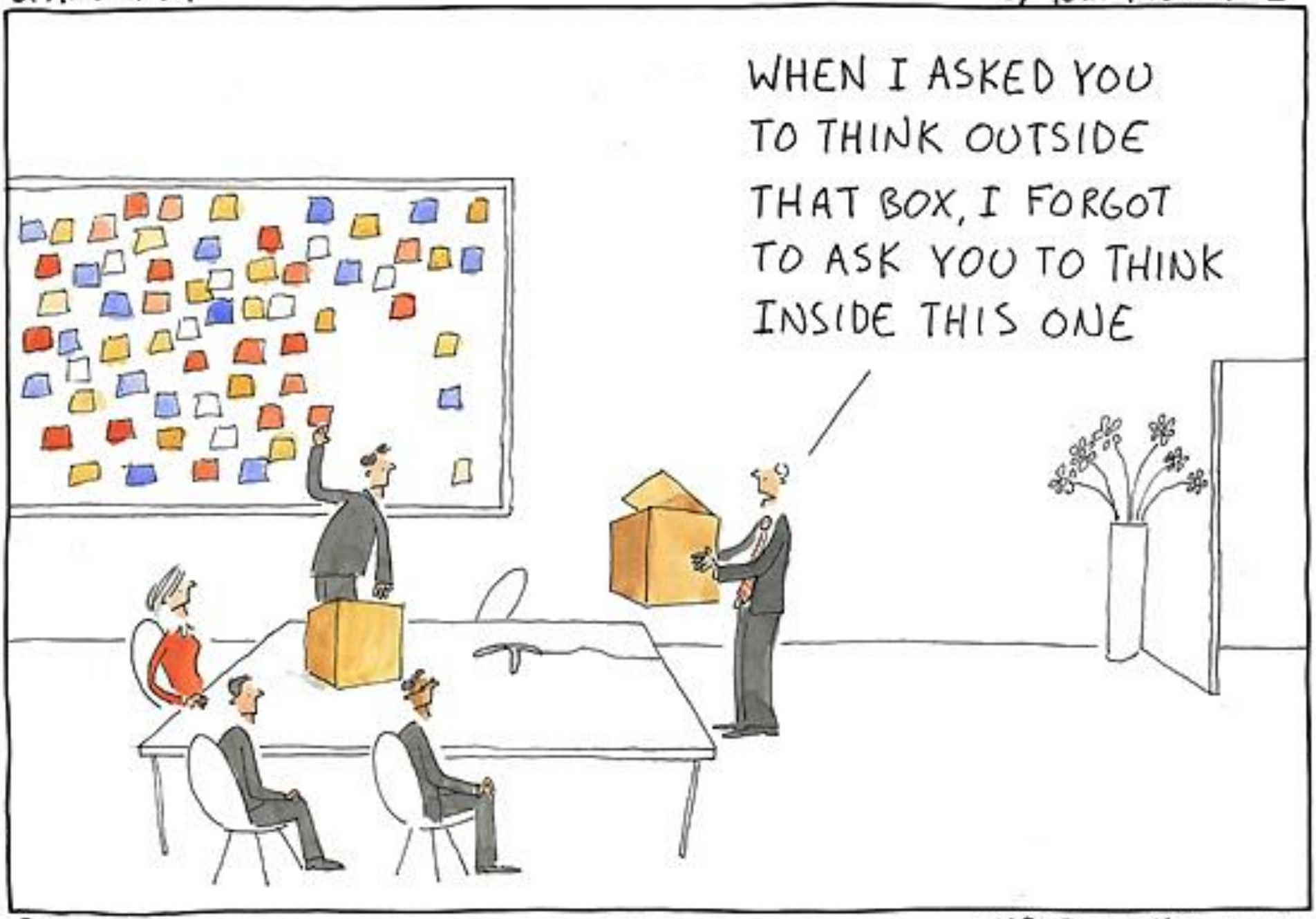
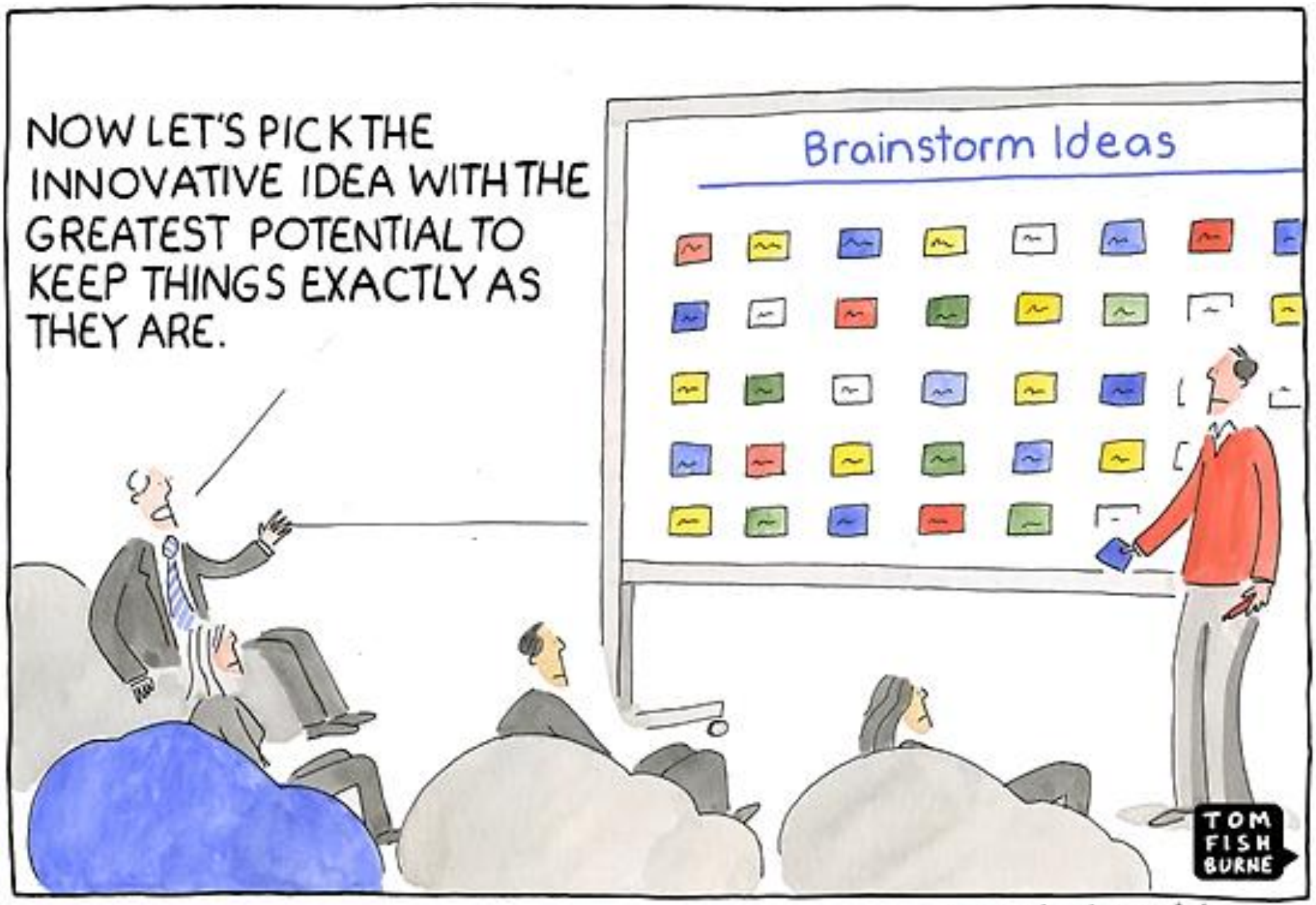
18	19	20	21	22
25	26	27	28	29 ★

★ **Deliverable:** Draft PHIP due to CMS

■ **May workgroup meetings**

by Tom Fishburne




NOW LET'S PICK THE INNOVATIVE IDEA WITH THE GREATEST POTENTIAL TO KEEP THINGS EXACTLY AS THEY ARE.
Brainstorm Ideas
TOM FISH BURNE
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Q&A

Next Steps

Next Steps

- The June full stakeholder meeting that was scheduled for **Wednesday, June 3, 2015** has been **rescheduled**. It will now take place on **Tuesday, June 9, 2015 from 1 – 4 PM** at the Kentucky Historical Society.
- **Mark your calendars!** The May and June stakeholder workgroups will be held as follows.

Workgroup	May Date	May Time	June Date	June Time	May and June Locations
Payment Reform	Tuesday, May 19th	9AM to 12PM	Tuesday, June 16th	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Integrated & Coordinated Care	Tuesday, May 19th	1PM to 4PM	Tuesday, June 16th	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Increased Access	Wednesday, May 20th	9AM to 12PM	Wednesday, June 17th	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Quality Strategy/ Metrics	Wednesday, May 20th	1PM to 4PM	Wednesday, June 17th	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
HIT Infrastructure	Thursday, May 21st	9:30AM to 12:30PM	Thursday, June 18th	9:30AM to 12:30PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601

- All stakeholder meeting materials and workgroup information is posted on the Cabinet's dedicated Kentucky SIM Model Design website here: http://chfs.ky.gov/ohp/sim
- Please contact the KY SIM mailbox at sim@ky.gov with any comments or questions

Thank you!